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DATE: May 21, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Hardening Program x 80 Hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The reviewer is certified by the American Board of Physical Medicine and Rehabilitation with over 16 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his foot after dropping a 50-60 encasement on his foot while working on xx/xx/xx.

07/25/14: The claimant was evaluated by a physician (illegible) at for right foot pain. He stated that he dropped an encasement for a pump on his foot that weighed about 50-60 pounds while at work. He went to where x-rays and a CT scan were performed demonstrating that he "broke 1st - 4th metatarsals on the right foot." He was placed in a fiberglass posterior splint. He reported that he had minimal pain. On exam, edema of the right foot and ankle were noted. Three fracture blisters were noted over the dorsolateral aspect of the right foot. Echymosis was noted throughout the right forefoot and ankle region. Sensation was decreased in both lower extremities. There was tenderness to palpation along the first, second, third, and fourth metatarsals of the right foot. He was able to dorsiflex and plantar flex his toes. Radiographs and CT scan were reviewed revealing displaced fractures of the midshaft of the first through fourth metatarsals with 4 mm of displacement at the midshaft involving the third and fourth metatarsals. Angulation deformities were evident of the second through fourth metatarsals. No fractures of the tarsal bones were evident. Surgical closed reduction with internal fixation was recommended. It was noted that he is a diabetic and was at high risk for wound complications.

10/17/14: The claimant was evaluated. It was noted that he required skilled physical therapy 2 visits per week for 4 weeks.

12/19/14: The claimant was evaluated for a fractured right foot and injury to bilateral knees and left foot. It was noted that he had received surgery with an implanted plate to the right foot. He had good range of motion of the right foot but reportedly did not receive physical therapy and did have some pain in the knees which previously had received TKRs in 2004. He had some pain in his left foot as well. It was noted that x-rays revealed healing fractures in the right foot with a plate over the 3rd metatarsal, bilateral TKR normal. He rated his pain as 4/10 dull-achy and burning. On exam, DTRs were 1 in the bilateral lower extremities. Scarring was evident from surgical procedures, swelling noted more in the right ankle and dorsum of foot. His gait was slow and slightly guarded with asymmetrical weight bearing favoring the right side on ambulation. T2P right ankle, foot, gastroc, soleus, and tibialis anterior muscles. Some tenderness of right ankle, more on the lateral aspect as well as the gastroc, soleus, and tibialis anterior muscles. Decreased AROM of both ankles secondary to pain. Slight decrease in muscle strength of the right ankle (tib anterior, gastrocs). Heel walk was within normal limits. Toe walk was difficult to perform due to pain. Assessment was increased pain, decreased strength, decreased AROM, and decreased functional tolerance. Goals were independent with HEP, normal mobility, strength increased by one grade throughout, and perform all ADLs without pain. Recommend 12 visits (3 days x 4 weeks) of postop rehab to increase AROM, strength, and functional tolerance, and decrease pain.

01/19/15: The claimant was reevaluated status post 12 visits of physical rehab. He complained of burning pain in the right foot rated 2/10. He reported symptom aggravation and increased pain during activities involving prolonged periods of driving. On exam, he had decreased bilateral ankle dorsiflexion, eversion, and inversion. Motor was rated 4/5 in the left big toe extension. Toe walk continued to be difficult to perform. Assessment was continued pain, decreased strength, decreased AROM, and decreased functional tolerance. Recommend continued rehab to further decrease pain and increase strength, AROM, and functional tolerance.

02/02/15: The claimant was evaluated. He rated his pain as 2/10 upon arrival to therapy. It was noted that he appeared to be in a good mood. He performed his required exercises well and without complaint. His pain level decreased after his session of rehab to 1/10. The plan was to continue with plan of care as tolerated.

02/04/15: The claimant was evaluated. He rated his pain as 1/10 upon arrival to therapy, and it remained the same after therapy. The plan was to continue with plan of care as tolerated.

02/17/15: A Functional Capacity Evaluation was made. It was noted that the claimant made objective improvements in range of motion, strength, and dynamic lifting. The remainder of the report is illegible.

03/07/15: The claimant was evaluated. It was noted that he had done well with his physical therapy 21 sessions and had reached a medium work level of 45 pounds. It was noted that a work hardening program had been recommended. Physical exam was unremarkable. It was noted that he was making very good progress and would benefit from a work hardening program. did not recommend that he be progressed to a heavy lifting level.

03/17/15: The claimant was evaluated. He was diagnosed with somatic symptom disorder with predominant pain, persistent, mild. For treatment recommendations/summary, it was noted that he would be an excellent candidate for the Work Hardening Program since the combination of intensive physical rehabilitation, work simulation, and didactic group psychotherapy services offered in the program may facilitate resolution of his functional deficits and mood disturbances, thus facilitating a safe and successful return to full-duty work. His FABQw score was 8, and FABQ physical activity score was 17. BDI-II was 0. BAI was 1. The plan of treatment was to include multidisciplinary rehabilitation with physical and behavioral modalities; participation in educational and process oriented group therapy with emphasis on relevant pain control techniques/strategies; minimum of 20-30 days participation in Work Hardening Program. The goals of treatment were to increase work endurance, tolerance, and return to gainful employment; decrease anxiety, decrease depression, increase an internal focus of control, resolve return to work barriers, and move forward to case closure. Physical therapy would include formalized PT/OT evaluation and FCE prior to program entry, extremity strengthening, core spinal stability training, stabilization, postural awareness, and balance training, strengthening/conditioning of the abdominal and paraspinals, passive and active stretching, sitting/standing intolerance, neuromuscular reduction, work simulation, biomechanics, ergonomic training, isometrics and kinetic training, free-weight and universal gym training, aerobic conditioning, and ADL training.

03/19/15: The claimant was evaluated. It was noted that he had not reached maximum medical improvement from his job injury and should continue his rehabilitation efforts with particular attention paid to improving range of motion. It was noted that his diabetic history and advanced age may complicate and prolong the rehabilitation process. Note was made that the claimant should be referred back to the podiatrist or to an orthopedic surgeon. A final note was made that the claimant should reach MMI within 4 months.

03/26/15: A preauthorization request for Work Hardening Program states: Because the patient is not able to meet the requirements to safely return to work without re-injury/aggravation, the patient is likely to benefit from a Work Hardening Program at this time. The patient is currently not working. The patient is likely to meet the required PDL to safely return to work with this program. The patient will be evaluated on a regular basis, and it is our expectation that they will return to pre-injury work status upon completion of the program. We expect they will regain full-duty status upon completion of the program.

03/31/15: UR. RATIONALE: Functional Capacity Evaluated dated 02/17/15 indicates that the required PDL is heavy and current PDL is medium. Designated doctor evaluation dated 03/19/15 indicates that the patient underwent surgical repair of the 1st, 2nd, and 4th metatarsal fractures followed by immobilization. This report states that the patient has not reached MMI. Initial behavioral medicine consultation dated 03/17/15 indicates that BDI is 0 and BAI is 1. The submitted records fail to establish that the patient has undergone an adequate course of physical therapy with improvement followed by plateau as required by the ODG. The submitted behavioral medicine consultation fails to document a significant psychosocial component which would require a multidisciplinary program.

04/10/15: A reconsideration request states: We requested 12 sessions of physical therapy and patient was only granted 9 sessions. He made great improvements to reach 45 pounds. His therapy ended on 2-16-15. The therapist that did final evaluation noted that "ASSESSMENT: Today patient came in to rehab with a positive attitude. He performed his required exercises well however complained of having slight burning pain in both feet. Patient's pain level remained the same after his session of rehab 1/10." He is currently working with light duty restrictions. He had impairment rating on 3-19-15 and deemed him not to be at MMI. He recommended continued rehabilitation exercises to improve his range of motion.

04/27/15: UR. RATIONALE: Updated documentation included physical therapy notes from 2014 to 2015. The updated documentation indicates that the patient has shown initial improvement with PT and has plateaued. However, psychiatric testing did not show significant psychiatric comorbidities to warrant multidisciplinary treatment. Therefore, the request for Work Hardening is not medically necessary, and the previous determination is upheld. The submitted behavioral medicine consultation failed to document a significant psychosocial component which would require a multidisciplinary program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse decisions are overturned. There is documentation of completion of 21 postoperative physical therapy sessions with improvement but continued functional deficit with medium capability versus heavy job demands. ODG is clear that work hardening is appropriate for medium job demands and higher (particularly given ODG recommended limited number of hours for work conditioning in order to meet that level of physical demand). Therefore, despite no to low psychometric testing, the large gap in current physical capabilities versus required job demands, a deconditioned state now 10 months post injury, as well as moderate levels of Fear Avoidance testing scores, is sufficient clinical finding to meet ODG criteria for interdisciplinary functional rehabilitation in the form of work hardening. Therefore, the request for Work Hardening Program x 80 Hours is medically necessary.

ODG:

Work	Criteria for admission to a Work Hardening (WH) Program:
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conditioning, work hardening	<p>(1) <i>Prescription</i>: The program has been recommended by a physician or nurse case manager, and a prescription has been provided.</p> <p>(2) <i>Screening Documentation</i>: Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.</p> <p>(3) <i>Job demands</i>: A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).</p> <p>(4) <i>Functional capacity evaluations (FCEs)</i>: A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.</p> <p>(5) <i>Previous PT</i>: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.</p> <p>(6) <i>Rule out surgery</i>: The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).</p> <p>(7) <i>Healing</i>: Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.</p> <p>(8) <i>Other contraindications</i>: There is no evidence of other medical,</p>
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	<p>behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.</p> <p>(9) <i>RTW plan</i>: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.</p> <p>(10) <i>Drug problems</i>: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.</p> <p>(11) <i>Program documentation</i>: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.</p> <p>(12) <i>Further mental health evaluation</i>: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.</p> <p>(13) <i>Supervision</i>: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.</p> <p>(14) <i>Trial</i>: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.</p> <p>(15) <i>Concurrently working</i>: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.</p> <p>(16) <i>Conferences</i>: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.</p> <p>(17) <i>Voc rehab</i>: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has</p>
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	<p>no job to return to.</p> <p>(18) <i>Post-injury cap</i>: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs).</p> <p>(19) <i>Program timelines</i>: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.</p> <p>(20) <i>Discharge documentation</i>: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.</p> <p>(21) <i>Repetition</i>: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.</p> <p>ODG Work Conditioning (WC) Physical Therapy Guidelines</p> <p>WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.</p> <p>Suggested Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.</p>
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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL &
ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY
GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR
GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW
BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN
ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE &
PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**